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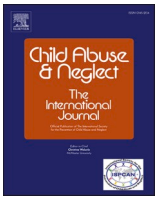

Improving professional practice in the investigation and management of intrafamilial child sexual abuse: Qualitative analysis of serious child protection reviews

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ABSTRACT

Background: Local multi-agency case reviews are regularly held in England when children have suffered significant harm from abuse or neglect, including from child sexual abuse (CSA). Most CSA takes place within families, is common but under-reported and can cause long-term harm.
Objective: The aim was to analyse English child protection reviews relating to intrafamilial CSA to identify improvements for professional practice.
Participants and setting: Local Child Safeguarding Practice Reviews (LCSPRs) and Serious Case Reviews (SCRs) relating to serious incidents of intrafamilial CSA occurring between 01 April 2017 and 31 March 2020.
Methods: LCSPRs and SCRs were obtained from the National Case Review Repository and thematically analysed.
Results: There were 243 reviews, of which 25 featured intrafamilial CSA. The main themes related to perpetrators, vulnerable families, and professional practice. Half of perpetrators were known by services to have previously abused children, but issues with professional practice enabled them to continue. Most children did not disclose CSA verbally showing challenging or sexualised behaviour; but professionals lacked knowledge and confidence on how to intervene without verbal disclosure, which limited safeguarding actions. Non-engagement by families with services was common, with some non-abusing parents complicit in abuse and deception. Significant neglect occurred in half the families, which diverted professional attention away from CSA.
Conclusion: CSA is deliberate abuse of children involving considerable deception by perpetrators in contrast to some other types of child abuse. This difference in abuser behaviour makes child protection more difficult, particularly when professionals do not recognise and respond to children's non-verbal disclosures.

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1. Introduction

The definition of child sexual abuse (CSA) used by child protection agencies in England is given in governmental statutory guidance on 'Working Together'. The latest 2018 edition specifies that CSA: 'Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening…' This definition includes non-contact activities, grooming and on-line abuse (HM Government, 2018b). CSA is thought to be under-reported, and it has been estimated that globally between 11.3 and 21.5 % of girls and 4.1–19.3 % of boys may experience CSA (Stoltenborgh et al., 2015). The 2019 Crime Survey for England and Wales estimated that 7.5 % of adults aged 18 to 74 (3.1 million) had experienced sexual abuse before the age of 16 (Office for National Statistics, 2020), although this includes non-familial CSA. A UK survey of children, young adults, parents and carers reported a life-time prevalence of any CSA of 5.3 % for young men, and 18.6 % for young women although intrafamilial CSA was much lower at 1.5 % for young men and 1.0 % for young women (Radford et al., 2013).

Intrafamilial CSA includes abuse by blood relatives, step-relatives or other people close to the child such as non-related household members, family friends or babysitters (Horvarth et al., 2014). Intrafamilial CSA accounts for two-thirds of CSA reported to police in England (Office of the Children's Commissioner, 2015) and more than 90 % of CSA in the USA (Centers for Disease Control and Prevention, 2022). A Canadian study found that intrafamilial CSA often starts at a younger age than extrafamilial CSA (Fischer & McDonald, 1998) and a UK study found that it may continue for many years (Allnock & Miller, 2013). Children often do not disclose their abuse verbally, but demonstrate distress by their behaviour (National Institute for Health and Care Excellence, 2017) . A survey of over 2000 children in the USA reported that CSA is associated with negative long-term outcomes such as poor physical and mental health and relationship difficulties (Fisher et al., 2017). A study for the UK Home Office estimated that, in the year ending March 2019, the economic and social costs of contact child sexual abuse alone came to over £10 billion in England and Wales (Radakin et al., 2021); and it was estimated to have cost the US economy $9.3billion in 2015 (Centers for Disease Control and Prevention, 2022). CSA is likely to be under-reported with an estimation that only 1 in 8 cases are reported to the police or child welfare services (Office of the Children's Commissioner, 2015).

Given that intrafamilial CSA is experienced by a significant minority of children and under-recognised, with potential long-term impacts, it is important to consider how professional practice can be improved. In England, if a child has suffered significant harm or died from abuse or neglect, the local multi-agency child safeguarding partners may conduct reviews of child protection practice. Serious Case Reviews (SCRs) were established in 1988 and were gradually replaced by Local Child Safeguarding Practice Reviews (LCSPRs) during 2018–19. Both SCRs and LCSPRs aim to identify improvements to practice to better safeguard and promote the welfare of children (HM Government, 2018b). LCSPRs and SCRs are written by independent authors, based predominantly on analysing documents and meetings with practitioners from all agencies directly involved in the case or with managerial responsibility. Families and young people are invited to contribute by sharing their experiences, their perceptions of professional interactions and whether any professional actions could have changed outcomes. There is usually a delay of several months until LCSPRs and SCRs are published, particularly if there are criminal prosecutions; not all are published particularly if there are concerns about identifying families and children.

Since 2015, our team have conducted analyses of all SCRs arising from incidents in 2011–14 (Sidebotham et al., 2016), 2014–17 (Brandon et al., 2020) and 2017–19 (Dickens, Taylor, Cook, Cossar et al., 2022) (commissioned by the Department for Education) and conducted analyses of all LCSPRs published in 2020 (Dickens et al., 2021) and 2021 (Dickens, Taylor, Cook, Garstang et al., 2022) (commissioned by the Child Safeguarding Practice Review Panel). These overviews of LCSPRs and SCRs look for cross-cutting themes in child protection practice, as well as specific analysis of particular types of abuse or groups of children, for example neglect (Dickens, Taylor, Cook, Cossar et al., 2022), and ethnicity and race (Dickens, Taylor, Cook, Garstang et al., 2022). To date there has not been a focus on intrafamilial CSA and analysis of LCSPRs and SCRs concerning intrafamilial CSA could provide unique insights into professional practice. As part of the 2017–19 analysis of SCRs the funder requested that we specifically analyse SCRs of intrafamilial CSA, which is reported in Dickens, Taylor, Cook, Cossar et al. (2022). This project builds on the analysis of intrafamilial CSA reported in SCRs by expanding the analysis to include additional cases from LCSPRs.

1.1. Aims

This study aimed to improve understanding of professional practice issues in SCRs and LCSPRs relating to children who had suffered significant harm from intrafamilial CSA. The research question was:

What are the common findings in SCRs and LCSPRs relating to intrafamilial CSA?

2. Methods

2.1. Study design

As part of our ongoing analysis of LCSPRs and SCRs, we identified reports relating to intrafamilial CSA where the incident date fell between 01 April 2017 and 31 March 2020. This was done by reading all published SCRs for the final biennial analysis 2017–19 (Dickens, Taylor, Cook, Cossar et al., 2022) and LCSPRs for the 2020 and 2021 annual reports (Dickens, Taylor, Cook, Garstang et al., 2022), and searching the National Case Review Repository (*National Case Review Repository | NSPCC Learning*, 2022) for any further reviews with incident dates in this time period (due to publication delays not all LCSPRs with incident dates within the time range were able to be included in the annual reports, but all SCRs had been published by the time of the final biennial analysis). We only included

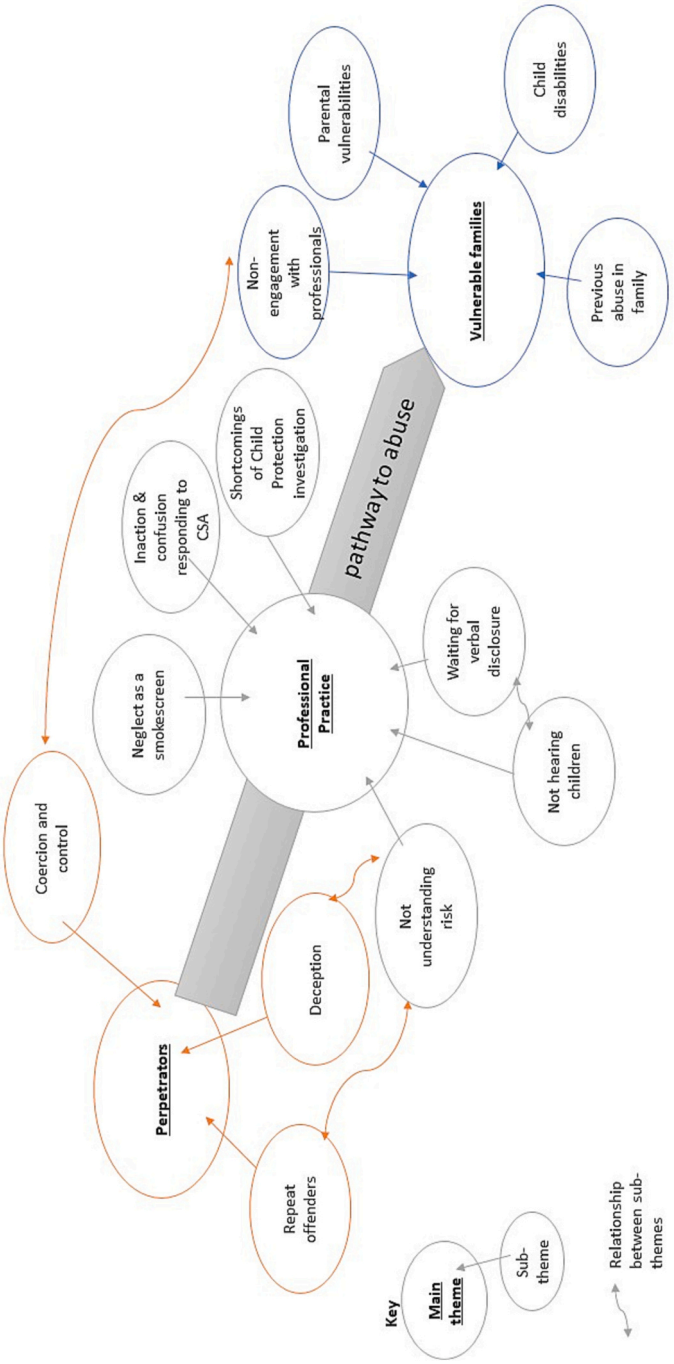

Fig. 1. Map of themes relating to intrafamilial Child Sexual Abuse

those reviews that were publicly available on the National Case Review Repository or Local Children's Safeguarding Partnership websites.

2.2. Procedure

We used qualitative thematic analysis (Braun & Clarke, 2022) to analyse the SCRs with QSR International NVivo V.12 software (*QSR International Pty Ltd NVivo (Version 12)*, 2018) to enable effective analysis and coding of the data. First, we read and summarised all SCRs noting key ideas for codes. Next, we re-read the SCRs to create initial iterative coding; these were re-evaluated inductively to create fewer codes which were then revised and refined with the whole research team, and are reported in Dickens, Taylor, Cook, Cossar et al. (2022). Subsequently we coded the LCSPRs using the SCR coding system creating additional codes as needed. Themes and sub-themes were iteratively refined and drawn into a theme map to consider how vulnerabilities, perpetrators and professional practice all interacted to contribute to abuse. Based on these findings we then considered how professional practice could be improved to offer better protection to children at risk of intrafamilial CSA. Quotes were selected to illustrate and represent data from each sub-theme. We continued coding all LCSPRs and SCRs although theoretical saturation of data was obtained after coding 20 reviews. We adhered to the consolidated criteria for reporting qualitative research (COREC) (Tong et al., 2007).

2.3. Research team

The initial SCR coding and analysis was conducted by JG, an experienced child abuse paediatrician and researcher. The coding was reviewed by other members of the research team including JT, a nurse and professor of child protection, and JD a professor of social work, both bringing a holistic safeguarding perspective. MM, a post-graduate neuro-psychology researcher, coded the LCSPRs jointly with JG.

2.4. Ethics

This study involved analysing published SCRs and LCSPRs that are in the public domain. It therefore did not require Health Research Authority ethical approval.

3. Results

There were a total of 166 SCRs and 117 LCSPRs publicly available for serious incidents between 01 April 2017 and 31 March 2020. Of these 25 reviews (16 LCSPRs, 9 SCRs) focussed on intrafamilial CSA. Reviews often featured more than one child being abused: 14 involved one child, five involved two children, six involved three or more with some stating ‘several’. The age range was from infancy to 17 years with 14 pre-pubertal children abused. The gender of children was not always stated but female children featured in 18 reviews and male children in three. Ethnicity was given as White British in five reviews, Black British/British Asian in one and not stated in 19. Perpetrators were identified in 22 reviews, all involving male perpetrators (fathers, mother's partners, other relatives), with one involving mother and her male partner. Four cases involved sibling sexual abuse.

3.1. Themes

The themes identified in the analysis could be grouped under three overarching headings: perpetrators, vulnerable families and professional practice. The relationship between these is shown in Fig. 1. Perpetrators targeted children from vulnerable families, with professional practice issues enabling abuse to continue. Continuing abuse could be seen as arising from an interplay of these themes. Note that this is a model for analytic purposes, so inevitably a simplification; the aim is not to capture everything about the complexities of behaviour and practice in this field, but to identify the main themes that came out of the reviews and give a sense of their inter-relatedness.

3.2. Perpetrators

In 14 reviews perpetrators had previously abused other children; 13 of these perpetrators were known to services; despite this they were able to deceive professionals and other family members.

> [Child] was 5 years of age when her mother and father separated…. Her mother became aware that her father had been arrested but believed it was for offences involving drugs. Her mother was later sent a link to a newspaper report, which indicated that father had been convicted of a sexual offence [with a child under 18 years of age] and received a term of imprisonment…. On his release from prison, [child's] father contacted her mother and asked for contact with [child]. Review 1.
>
> Unknown to the family or any of the professionals working with [child] and her mother at the time, [mother's partner] was a registered sex offender, regularly visited by police in his ‘home’ town (Area 2) in line with multi-agency public protection arrangements (MAPPA). [The mother's partner] repeatedly reported to officers on these occasions that he had no contact with children and was not in a relationship with anyone. Review 2

In the case immediately above high workloads and inadequate supervision contributed to errors in Multi-Agency Public Protection

Arrangements (MAPPA), which enabled the abuse to continue for many years.

> …Although RMOs [Risk Management Officers] are specially trained, police officers are perhaps naturally more inquisitive, more suspicious, and challenging. This left the review team to conclude, without being able to explore with any of the RMOs involved, that the risks [mother's partner] posed were not identified or well understood…… Due to the high numbers of persons requiring to be managed, combined with the administrative burden and the high turnovers of line managers. This, the review team were told, led to an increase in stress and sickness levels for staff, and made it more likely that risks in some situations were not recognised. Review 2

In 12 families, there was coercive control by perpetrators to prevent disclosure by children or non-abusing parents, and non-engagement with services was common.

> It is highly likely that several family members were aware that this was happening, but it was a family with "secrets" and a coercive and, at times, violent culture driven by Sibling 1 and supported by his father who did not appear to challenge what was happening. Review 3.
> What is known now but could only have been guessed about at the time, is the power of the control that some of the adults in [family] maintained over the children and over anyone within the family who might be in a position to disclose what was taking place… The children were effectively controlled by various means from direct threats, for example to kill a pet, to manipulation of their vulnerabilities, for example one seriously neglected child told Police that at least when they were at [Family's] house they were given a sandwich. Review 4.

3.3. Vulnerable families

3.3.1. Pre-existing vulnerability

There were pre-existing vulnerabilities in 19 families with mothers having one or more of issues including mental health problems, learning disability or experiencing domestic abuse.

> Both parents had disrupted childhoods, Father experienced neglect and abuse and had been a child looked after [foster care]. As an adolescent, there were allegations in respect of Father's harmful sexual behaviours. Mother experienced anxiety and depression. Review 5

In some this led to children being placed by social care with extended family where they were subsequently abused.

> Prior to entering care [children] witnessed extensive and serious domestic abuse between their mother and father…Following further violence between the parents and a deterioration in mother's mental health, they were placed with [carers] as kinship carers. Review 6

3.3.2. Child disability

Four children attended special educational needs schools due to learning disabilities and were particularly vulnerable. One young woman despite sex and relationship education had not been able to recognise that her mother's partner was abusing her. In all four cases, behaviour problems were seen as due to the children's underlying conditions and other causes were not explored.

> [child's] apparent 'difficult' behaviours as she grew older seemed to be attributed to her ADHD and learning disability diagnosis and a lack of structure and consistency in the home environment. Consequently, the reasons for [child's] difficult behaviours as reported by [mother], were never fully explored, or queried in any depth by professionals involved with the family. Review 2
> The experience of this child and those professionals supporting her reflects what is more widely understood about protecting children with disabilities from abuse. Some of her behaviours, such as banging her head and rocking, seemed to have been understood as a result of her disabilities. Review 4

3.3.3. Previous abuse in the family

In six families, older siblings had previously been abused by other intra-familial perpetrators. This suggests that these families may have been unable or unwilling to identify risks, were not offered or able to access help and support, or at worse had been complicit in the abuse. Two mothers did not alert professionals when children told them that younger siblings were being abused. One of these mothers had been abused in childhood by the same relative and did not feel able to discuss what she had been told with her child or their social worker.

> Maternal grandmother's former partner [who had been considered a risk to children] was also an occasional visitor to the family home. Maternal grandmother had told her grandchildren's social worker, however, that 'she didn't have the kids in the house when (this person) visited because of the allegations made about him and in order to protect him'. Review 7

3.3.4. Non-engagement with professionals

In nine families, parents avoided engaging with professionals making it much more difficult for concerns to be investigated. This included refusing to acknowledge the children's behaviour difficulties, deliberately misleading professionals, or outright hostility and

physical intimidation. One family did not allow their children's allegations of CSA to be investigated, which resulted in 'No Further Action' decisions from agencies: this is clearly sub-optimal practice but the reasons for this were not detailed in the review. In some of these families non-abusing parents made strenuous attempts to prevent investigations. This may have been because they themselves were victims of coercive control or domestic violence, or due to neglect, but in some cases the non-abusing parent may have been complicit in the abuse.

> There is frequent reference to one parent being threatening both to staff at school and to Social Workers. She kept an aggressive dog in the home, which on one occasion was used to chase Police Officers away. Her behaviour at school was so threatening that she was banned. She told a Social Worker directly that she would not let her into the house. Then, for several months whilst the children were on Child Protection Plans, she either did not respond to Social Workers or actively refused them entry. Review 4

This shows the particular vulnerability of these families, given that if children do make verbal disclosures of sexual abuse, they will typically disclose to their non-abusing parent (Clayton et al., 2018).

3.4. Professional practice

3.4.1. Waiting for verbal disclosure

Social workers, healthcare and school staff frequently struggled to recognise that children were being sexually abused, waiting for children to verbally disclose abuse, preventing effective action being taken. In 12 families, children only disclosed sexual abuse after they had been moved to a place of safety, or when they were directly asked. The reviews often found that professionals lacked skills and knowledge in how to manage situations where there was no formal disclosure of sexual abuse; they were often concerned about the behaviours but felt unable to act.

> …there is the accumulation of evidence strongly indicating that the youngest child had been either sexually abused, exposed to inappropriate sexual material or witnessed sexual abuse as a third party. The concerns from the primary school, Police intelligence reports and direct experience from the professionals involved with the family needed to be brought together through a Section 47 [statutory multi-agency] strategy discussion. In this instance, despite the multi-professional concerns, a Strategy Discussion was not initiated. Review 8

Nearly all children showed their distress through behaviour difficulties, most with aggressive, challenging, and sexualised behaviour so in effect they were disclosing through their actions rather than through words. Children could present with extreme behaviour difficulties, with two children requiring placement in special schools for children with emotional and behavioural difficulties. Even when there were escalating concerns of sexualised behaviour, professionals did not consider whether sexual abuse might be implicated.

> The issue of the children using sexually explicit language and exhibiting sexualised behaviour was explored in [two] single assessments, at strategy meetings, [two] Child in Need Meetings, core group meeting and Initial Child Protection Conference but only in a superficial way. There was no real analysis of why it was occurring or formal recognition that abuse could be happening in the family setting. Review 9

LCSPRs identified the issue of lack of professional confidence in dealing with situations where no formal disclosure of sexual abuse had been made, and several reviews recommended further training and improved local guidance for practitioners.

3.4.2. Not hearing children

In nine reviews, children (aged between 8 and 16 years) were not spoken to alone by social workers reducing the opportunity for disclosure. In one case, involving siblings in kinship care, they explained being torn between wishing they had a chance to tell the social worker and fear of this.

> We used to have to be so careful as the family were in the room. We never got offered to be seen alone – maybe we should just have been taken. Social workers could have taken us out, they just used to sit us down at home. I would have loved to have gone out without my siblings. Everything you said to the social worker got repeated back to the carers anyway. [young person] Review 10

This points to the importance of relationship based social work, building relationships with children, so that they can feel secure enough to share their concerns and feelings. Children are most likely to disclose abuse to their non-abusing parent (Clayton et al., 2018), but children in out-of-home placements may be unable to do this, making consistent relationships with caring, well-trained and well-supported foster carers even more important, as well as with social workers.

3.4.3. Inaction and confusion when responding to CSA

When professionals did identify that CSA was a distinct possibility, or following a disclosure, the response was sometimes characterised by confusion and inaction. Ten children made disclosures of abuse while living at home, but this did not lead to any meaningful change or effective safeguarding for them.

> The direct statements by him of inappropriate behaviour from family members offered a clear opportunity to form a view that he was not being protected by a Child Protection Plan and that his current care arrangements were ineffective in keeping him safe. Review 11

One child presented with genital injuries following several months of concern about sexualised and aggressive behaviour, but professionals were still uncertain about what actions could be taken in the absence of a clear (verbal) disclosure.

> The paediatrician stated that she had made it clear to those in the [strategy] meeting that she had a high level of suspicion that [the child] presented with injuries of sexual abuse and was advising that a specialist sexual abuse examination needed to be arranged immediately….the children's services manager said there is 'no disclosure, only suspicion of sexual abuse and therefore insufficient evidence to reach threshold for Section 47 [statutory investigation] …' Review 9

The threshold for statutory investigation includes 'reasonable grounds to suspect' that a child is suffering significant harm, so in this case the manager had misinterpreted these. The review concluded that some professionals had felt the need to have a criminal burden of proof to commence statutory enquiries, which prevented effective safeguarding and was contrary to national guidance.

In seven cases, children were not referred appropriately for child sexual abuse medical examinations, which are recommended for any child who has made a disclosure or where there is a strong suspicion of abuse (Royal College of Paediatrics and Child Health, 2020). Social workers did not understand the value of these assessments considering them primarily for forensic evidence collection and intrusive and traumatic, rather than as a holistic medical assessment.

> Discussions for this review have highlighted the tendency to view medical examinations as intrusive and only required at a point in an investigation where they may provide forensic evidence for civil or criminal proceedings. This does not recognise their potential for providing a safe place where children can be listened to and have the opportunity to describe any worries and fears. Review 12

3.4.4. Physical symptoms of CSA

Eight children presented with physical symptoms associated with CSA, which included urinary tract infections, soiling and rectal bleeding. In six children there was no consideration of CSA as a potential cause. The reasons for this were unclear but review authors concluded this may have reflected inadequate knowledge. One teenager with learning disability attended the GP 12 times in three years with genitourinary symptoms but was never asked about her sexual history; this is contrary to UK clinical guidance (National Institute for Health and Care Excellence, 2018). Lack of information sharing with family doctors and specialist paediatricians also prevented holistic understanding of children's symptoms. In one case, there was concern about possible CSA due to physical symptoms and sexualised behaviour, but this information was lost during the referral process and the subsequent lack of physical evidence provided false reassurance, enabling the abuse to continue.

> There were opportunities to focus on sexual abuse as a result of medical symptoms as a young child. At this stage, [child] remembers hoping that doctors would realise what was happening as she could not say anything directly about life at home as she had been told to keep quiet by her parents. She also remembers staring hard at professionals hoping that they would realise that something was amiss… When [child] was referred to the gynaecologist at age 10, the gynaecologist was not aware that she was subject of a child protection plan and having spoken to her parent wrote in the records "no worries about abuse". Review 13

This LCSPR recommended improvements to medical assessments with pre-pubertal girls to be assessed jointly by gynaecologists and paediatricians and the establishment of a paediatric Sexual Assault Referral Centre (SARC).

3.4.5. Not understanding risk

Twelve cases occurred in families with previous histories of CSA. These featured inadequate or missing risk assessments and lack of information-sharing between agencies on the potential risk posed by perpetrators. The reasons for these shortcomings were not specified, but it should have been recognised that these children were living in high-risk environments.

> The assessment was never updated or reconsidered in light of new information, such as when an adult female made allegations of sexual abuse against the children's father. This led to the risk of sexual harm to the children being unassessed. There was a need for a holistic assessment to identify any vulnerabilities, family dynamics and needs of the adults and children to determine whether the children could be protected and that the person responsible in protecting the children had the capacity and ability to do so. Review 14

Another example relates to a girl in a family where her older siblings had been removed due to sexual abuse by their father; the girl was returned to her mother's care following social care and forensic psychology assessment. The mother then started a new relationship with a man who subsequently abused the girl. There was minimal acknowledgement by social care of the risks faced by this child, given the previous significant abuse in the family; furthermore, the court required safety plan was not developed and there was a lack of management oversight.

> [Social worker 4] indicated that as no concerns emerged in relation to [girl], school were actively involved and the authority and legal processes had deemed it safe to reunite the family, …focus was placed on more pressing cases considered to be of higher risk. [Social worker 6] also attributed the lack of managerial oversight in this case to focusing more on the perceived

> higher risk child protection cases held at that time ….the case was not seen as a high priority, and supervision and managerial oversight on this case was not as robust as it should have been. Review 15

This inadequate understanding of risk was further illustrated when the girl retracted an allegation, and despite pre-existing concerns of this possibility and uncertainty around mother's ability to protect her, the retraction was not considered in a multi-agency forum. This resulted in the child remaining at home with her abuser and suffering further abuse.

> [girl]'s letter did not spark enough healthy scepticism by CSC professionals, as might be expected, evidenced by the decision not to seek the views of other professionals but to speak only with [girl] about her letter…..what was missing was any evidence that the content, context and circumstances of [girl's] retraction had been as carefully and well considered by CSC and agency partners as was her initial allegation. Review 15

3.4.6. Neglect as a smokescreen

There was significant neglect in 14 families, which dominated interactions with professionals who focused on the neglect; the sexual abuse then continued despite ongoing social care investigations or support. Children's behaviour problems were viewed as due to poor parenting and emotional abuse, and sexualised behaviour sometimes ignored.

> It would appear from the records made available to the review and from the practitioners' event that many of the professionals who had been involved in this case were seeing neglect as the primary issue which was affecting the family. The social care manager on the panel felt that often the term neglect was used in its wider context and the understanding of interfamilial abuse was limited. As a consequence of this focus on neglect in this case and the absence of a disclosure those dealing with the family lost sight of the fact that sexual abuse could have been occurring in the family. Review 9

Conversely, in one case the focus on CSA investigations meant that severe neglect went unrecognised until the children were placed in foster care.

3.4.7. Impact of shortcomings in other child protection investigations

In 21 cases, there were issues with other child protection investigations unrelated to sexual abuse; these contributed to children remaining in homes where they suffered sexual abuse. One child presented with possible non-accidental injury (a bruised eye); the limited enquiries did not detail all adults in the household which may have revealed mother's partner being subject to offender management due to previous CSA.

In two families, children were abused by kinship foster carers. In the UK, children in care have six monthly welfare and progress reviews, but in these cases they were superficial and did not challenge the view of the children being in a positive placement despite their challenging behaviour, concerns of neglect and overcrowding. Inadequate initial kinship care assessment meant that children were placed in unsafe homes with unsuitable carers. There is considerable pressure (and benefits) to place children with extended family, and there are adapted, 'proportionate' standards for placements with relatives, although of course these do not warrant ill-treatment. Whatever the legal arrangements for the placement, the assessments still need to be rigorous, and any ongoing supervision should be astute and focused on the wellbeing of the children (Farmer & Moyers, 2008; Harwin et al., 2019; Masson et al., 2019).

> The Special Guardianship Report (SGO) [Kinship Care] was not sufficiently thorough in assessing potential risks to Child G. In particular, more information should have been sought with regard to the historic allegations of abuse, so this information could have been analysed more thoroughly. The SGO report recommendation was made without the writer having sight of the Disclosure and Barring Service report. The recommendation for the SGO was also made without reference to the medical checks or without speaking to Mr. A's daughter and stepdaughter. These were necessary checks as part of the Special Guardianship Order assessment process. Review 16

In six cases, severe neglect had persisted over a long period and had been the focus of child protection investigations. In these cases, there were issues such as case drift, lack of focus, little meaningful change for children, poor information sharing and over-optimism; these led to the children remaining at home with their abusers despite thresholds for removal being met.

> The dissonance between the children's apparent presentation at times, the home environment and family dynamics they were living in, should have raised concerns. Staff should have displayed more professional curiosity and thought 'what does the child mean to the parent and what does the parent mean to the child?' This approach challenges the optimistic view that their circumstances had sufficiently improved. Review 17

Although children remaining at home despite reaching removal thresholds is relatively common in neglect cases, the basis for this is that the risks are correctly identified and carefully assessed. This was not the situation in the cases with neglect and CSA as the CSA remained hidden, leading to greater harm. Had the earlier management of non-CSA safeguarding practice been better, with good supervision, reflective practice and case management, the children may have been protected from CSA significantly earlier.

4. Discussion

We analysed 25 reviews relating to intrafamilial CSA, the majority involving pre-pubertal children, particularly girls abused by men. In half, perpetrators had previously abused other children and this abuse was known to services or families, but inadequate

understanding of risk, offender management, high workloads or failures of information sharing enabled further abuse. Non-engagement with professionals occurred in many families, which may have been due to coercion and control by abusers, but in some, non-abusing parents were complicit in abuse. Few children gave verbal disclosures of abuse while they remained in the family home, although most displayed their distress by challenging or inappropriate sexual behaviour. Professionals sometimes did not have the knowledge or confidence to take protective action without a verbal disclosure, enabling abuse to continue. In half of families there was significant neglect alongside CSA, which diverted professionals' attention as it became the focus for child protection enquiries.

4.1. How can we protect children better from intrafamilial CSA?

4.1.1. Understanding and challenging deception

It is a challenge for professionals to protect vulnerable families from perpetrators who deliberately abuse children and employ considerable deception of others to do so. This contrasts with other forms of abuse such as neglect when parents do not prioritise children's needs leading to harm by omission, and physical abuse is often not planned but occurs when parents lose control. This fundamental difference in abuser deception makes child protection more difficult, although it is not confined to CSA cases – it was a notable feature in two recent high-profile cases in England. Star Hobson and Arthur Labinjo-Hughes died following prolonged periods of severe physical and deprivational abuse inflicted by their parents and step-parents despite being known to social care. This led to a national review of child protection which has recommended the establishment of multi-agency child protection hubs to facilitate joint case management with multi-disciplinary teams including psychologists, psychiatrists and paediatricians as well as social care and police bringing senior expertise central to child protection investigation and planning. This would help ensure that inexperienced professionals are not managing complex cases with inadequate supervision and support (Child Safeguarding Practice Review Panel, 2022).

Non-engagement with services is frequent in child protection work but it is important to consider the reasons behind this. Although often parents find it difficult to change entrenched habits, in CSA cases it may be a deception tactic. We should be able to look beyond neglect and emotional abuse in complex families to consider alternative explanations for challenging behaviour. This is particularly important as long-term outcomes are even poorer for children who experience other forms of abuse and neglect as well as CSA (Finkelhor et al., 2007).

4.1.2. Supporting families where children have been abused previously

We found that many perpetrators had offended previously. Research suggests this is common with recidivism rates for CSA of 13–20 % (Marques et al., 2005) or even higher at up to 42 % with 10 % occurring more than 10 years after the original offence (Hanson et al., 1993). Given this high risk, when known perpetrators are living with families there should be robust up-to-date risk assessments, which are regularly reviewed particularly when new information becomes available. Information should be shared with relevant professionals working with such families, so that they can be alert to any potential signs in children particularly as children rarely disclose abuse directly.

Some families seemed particularly vulnerable with older children being abused then different perpetrators abusing younger ones. These families may not have been adequately supported by services to recognise risks or some parents/carers may have been complicit in abuse. While much of safeguarding focuses on working with families, on occasion professionals may need to consider the unpalatable reality that some parents/carers deliberately harm children to satisfy their own needs and will use deception or whatever means available to achieve this. In many countries there are schemes such as the Child Sex Offender Disclosure Scheme (Sarah's Law) (Child Sex Offender Disclosure Scheme, 2021) which allows parents to check if someone with access to their children has been convicted or suspected of child abuse. These could be promoted to particularly vulnerable families: through special schools and support services for children with disabilities, and by social care working with families where children have previously been abused.

4.1.3. Safeguarding children without waiting for verbal disclosures of CSA

Some professionals appeared to lack knowledge in how to recognise and investigate concerns of CSA, in particular feeling they had to wait for a verbal disclosure to intervene. Doctors appeared to lack knowledge and at times missed physical symptoms of abuse. In common with other research, most children in these reviews did not verbally disclose the abuse but disclosed non-verbally by showing challenging or sexually inappropriate behaviour (Cossar et al., 2019; Jones & Taylor, 2018; National Institute for Health and Care Excellence, 2017). Professionals are rightly worried about asking leading questions and contaminating evidence preventing any eventual criminal prosecution, but this may need reconsideration given that only a tiny proportion of CSA cases are prosecuted (Horvarth et al., 2014) but all will need a child protection response. The threshold for criminal convictions should not become the starting point for a child protection enquiry for CSA.

The UK Independent Inquiry into Child Sexual Abuse has recently concluded. It predominantly focused on abuse within institutions but also included recent accounts of intrafamilial CSA and the response by social work and other safeguarding partners. Adult survivors recounted how their behaviour and mental health deteriorated following CSA, and despite contact with professionals no-one sought to understand the reasons for their distress. Survivors said that they wanted to be asked directly by professionals if they were being sexually abused as this would have enabled them to disclose the abuse (Jay et al., 2022). Similarly, some children in this analysis only disclosed abuse when directly asked, and others wished that they had been asked. It may be that we need to consider asking children more often about CSA. In any case, sexually inappropriate behaviour should be viewed as a 'red flag' for sexual abuse, considered in a multi-agency forum and if necessary, safeguarding investigations started without waiting for a verbal disclosure. The Independent Inquiry has recommended that it becomes mandatory for professionals to report allegations of CSA. This has previously been

considered in the UK but following consultation with child protection professionals felt to be unhelpful potentially leading to many more referrals, diverting attention away from more serious cases without ensuring that appropriate protective action would be taken (HM Government, 2018a). Mandatory reporting of CSA may only have a limited impact given the few verbal disclosures made by children, the difficulties for professionals in recognising abuse, and as this paper has shown the shortcomings in child protection processes even when the concerns have been raised. Many schools teach CSA prevention programmes, these have been shown to increase children's knowledge and self-protection although they may not increase their ability to make disclosures (Walsh et al., 2015).

Given that few children disclose CSA verbally, professionals should be prepared and empowered to initiate safeguarding procedures if children are displaying behaviour highly suggestive of CSA. There is official guidance for joint social work-police interviews of children when CSA is suspected, which are video-recorded for evidential purposes, Achieving Best Evidence or 'ABE' interviews (Ministry of Justice & National Police Chiefs Council, 2022), but even before that, professionals should be trained and supported to have in-depth conversations with children that enable them to talk about what is happening, without asking leading questions. This relies on good quality relationships between professionals and children so social workers and others need adequate time and emotional space for potentially difficult meetings, otherwise encounters risk being superficial with children not properly seen and heard. After such meetings professionals should be enabled to reflect critically on them focusing on what they have or have not heard or seen (Ferguson, 2017). Similarly, it can be difficult building a meaningful relationship with children when there is a hostility between parents and social workers; sometimes with workers mirroring parents' distrust. Skilful relationship-based practice is needed to allow children's voices to be properly heard (Ferguson et al., 2021).

4.1.4. Supporting children during CSA investigations

Children are most likely to disclose intrafamilial CSA to their non-abusing parent, although a US study found the responses to these disclosures are often negative with children not believed, dismissed or subject to violence (Elliott et al., 2022). The few children in these reviews who disclosed to parents had mixed experiences, with some parents being very supportive and immediately informing police or social care but others taking no protective actions. Following disclosures, professional actions were often ineffective. Low rates of satisfaction with the professional response to allegations of CSA (both intra and extrafamilial) have been reported in other countries as well; for example, in one Swedish study 35 % were satisfied with police responses and only 20 % satisfied with social care (Landberg et al., 2022). Children are likely to be more at risk if they do not have regular contact with trusted adults or family members if they live in out of home care, or there are other safeguarding concerns in the home.

Some professionals in the USA consider CSA examination as unhelpful and potentially traumatising for children (Morris et al., 2017). We noted a similar reluctance to refer for specialist CSA medical examination although a recent small-scale study in Ireland reported that these are not traumatic when performed sensitively, and can be very helpful in assuring children, even months later, that they have not been harmed by the abuse (O'Keeffe & McElvaney, 2022). The value of such holistic medical evaluations for children should be recognised, and children routinely offered these as part of support and investigative processes.

4.1.5. Keeping an open mind

Many of the issues in these reviews related to 'tunnel vision' when professionals had made certain assumptions about a situation and then did not consider further evidence that may have challenged their view. For example, for some children who were showing challenging or sexualised behaviour this was thought to be due to their previous experiences of trauma or abuse and the possibility of ongoing abuse not considered. Kinship care placements were assumed to be good, and any difficulties were viewed as the carers valiantly trying to cope with challenging disruptive children; the alternative explanation of children displaying their distress due to ongoing abuse was not considered. In families with chronic neglect, this was seen as the reason for children's difficulties and CSA continued to be perpetrated despite social care interventions. Professionals need to remain open-minded and deliberately seek out information that may oppose their current viewpoint as part of ongoing assessments and support. The impact of confirmation bias is well recognised in children's social care (Kirkman & Melrose, 2014), particularly when social workers have inadequate time for contacts and reflection afterwards (Ferguson, 2017), and different cognitive biases may contribute to diagnostic inaccuracies and medical errors resulting in patient mismanagement (Saposnik et al., 2016). Regular supervision either by a supportive, available manager or peer-group sessions should enable effective reflective practice promoting high-quality social work (Ravalier et al., 2022), this is especially important when working with hostile or resistant families (Ferguson et al., 2021).

4.2. Strengths and limitations

This is the first study to analyse reviews of safeguarding practice in intrafamilial CSA in England, and we acknowledge its limitations. Whilst we were able to access 25 LCSPRs and SCRs, there may be others addressing the subject that are not published, possibly to avoid identification of families. These reviews take place when a child has suffered significant harm and there is concern about multi-agency working; the decision to carry out a review is to some extent subjective, meaning that the included cases are likely to be the 'tip of the iceberg' of serious harm and professional failings, particularly as child sexual abuse is known to be very under-reported (Kelly & Karsna, 2017). Additionally, there are no comparison reviews for cases where safeguarding actions were effective and timely, although by focussing on cases with the greatest concern about professional action there is the potential for the most learning. LCSPRs and SCRs are not written for a research audience but to improve professional practice, so the quality, detail and methods may vary significantly which will impact on their value as research tools. These issues may reduce the reliability of our findings, as the cases included may not be representative of intrafamilial CSA cases in general. However, our findings echo those of six 'Joint Targeted Area Inspections' (JTAIs) in different areas in England into the experiences of children and young people subject to, or at risk of,

intrafamilial CSA. These multi-agency inspections were carried out between September 2018 and May 2019, and found similar concerns of professionals waiting for children to verbally disclose abuse and not looking at the underlying reasons for children showing inappropriate sexual and challenging behaviour (Ofsted et al., 2020). Furthermore, our analysis was enhanced by our multi-agency research team of expert clinicians and social care practitioners, leading to new insights in an under-researched area.

4.3. Conclusion

Professionals may need to reconsider how they work with families where there are concerns of intrafamilial CSA, becoming more aware of the likelihood of deception and coercion and be prepared to investigate concerns with families robustly and persistently. They need to look past concerns of neglect to consider why families may not engage with services. Children may only tell of CSA by their behaviour, and when necessary, this should lead to intervention without waiting for a direct verbal disclosure. Safeguarding in intrafamilial CSA is challenging work for professionals who will need support, time, resources, and supervision to be effective.

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Declaration of competing interest

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Data availability

All data used for this study are publicly available from the NSPCC National Case Review Repository https://learning.nspcc.org.uk/case-reviews/national-case-review-repository

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